

<b>Case Number:</b>	CM15-0028608		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	07/29/2014
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 34 year old female, who sustained an industrial injury on 7/29/2014. She has reported sudden left shoulder pain that subsequently radiated to neck, back and arm. The diagnoses have included impingement syndrome, scapular dysfunction, left rotator cuff tendinitis, cervical spine strain, and left sided cervical radiculopathy. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesic, steroid joint injections to shoulder, home exercise and activity modification. Currently, the IW complains of no improvement with continued self treatment. On 2/2/15, the physical examination documented tenderness to cervical spine and trapezius muscles and decreased cervical Range of Motion (ROM) with pain. Thoracic examination documented tenderness to paravertebral muscles and limitation in motion. The shoulder was also tender, positive impingement sign, and greater decreased Range of Motion (ROM). The plan of care included requesting authorization for an orthopedic consultation to discuss left shoulder arthroscopy, chiropractic visits for cervical spine, Magnetic Resonance Imaging (MRI) of cervical spine, and electromyogram studies. On 2/6/2015 Utilization Review non-certified six (6) chiropractic therapy sessions (twice a week for three weeks), an orthopedic surgeon consultation, and electromyogram and nerve conduction study of right upper extremity, noting the documentation did not support that the guidelines had been met. The MTUS and ACOEM Guidelines were cited. On 2/17/2015, the injured worker submitted an application for IMR for review of six (6) chiropractic therapy sessions twice a week for three weeks, orthopedic surgeon consultation, and electromyogram and nerve conduction study of right upper extremity.

## IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

### **6 Chiropractic Visits for the Cervical Spine (2 times a week for 3 weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care, Manual Therapy & Manipulation, Treatment, Pages 58-60.

**Decision rationale:** MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. The intended goal is the achievement of positive musculoskeletal conditions via positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved functional status from previous chiropractic treatment already rendered. Clinical exam remains unchanged without acute flare-up, new red-flag findings, or new clinical findings to support continued treatment consistent with guidelines criteria. It appears the patient has received an extensive conservative treatment trial; however, remains functionally unchanged without functional restoration approach. The 6 Chiropractic Visits for the Cervical Spine (2 times a week for 3 weeks) is not medically necessary and appropriate.

### **Consult with an Orthopedic Surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, Shoulders, Surgical Consult, pages 209-210.

**Decision rationale:** Medical necessity has not been established nor has findings met criteria for surgical consult per MTUS Medical Treatment Guidelines. MTUS Guidelines clearly notes that injured workers must have clear clinical and imaging findings consistent with a surgical lesion to support for consultation. Submitted reports have not demonstrated any surgical lesion or indication for surgical consult when the patient has unremarkable progressive and traumatic clinical findings without red-flag conditions. Examination has no specific neurological deficits to render surgical treatment nor is there any diagnostic study with significant emergent surgical lesion or failed conservative care failure. The Consult with an Orthopedic Surgeon is not medically necessary and appropriate.

**Electromyography/Nerve Conduction Velocity (EMG/NCV) of right upper extremity:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chapter 8 Neck & Upper Back, Special Studies and Diagnostic and Treatment Considerations, pages.

**Decision rationale:** Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, or entrapment syndrome, medical necessity for EMG and NCV have not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any cervical radiculopathy or entrapment syndrome, only with continued diffuse pain without specific consistent myotomal or dermatomal correlation to support for electrodiagnostics for a patient without any report of new injury, acute flare-up, or red-flag conditions. The Electromyography/Nerve Conduction Velocity (EMG/NCV) of right upper extremity is not medically necessary and appropriate.